

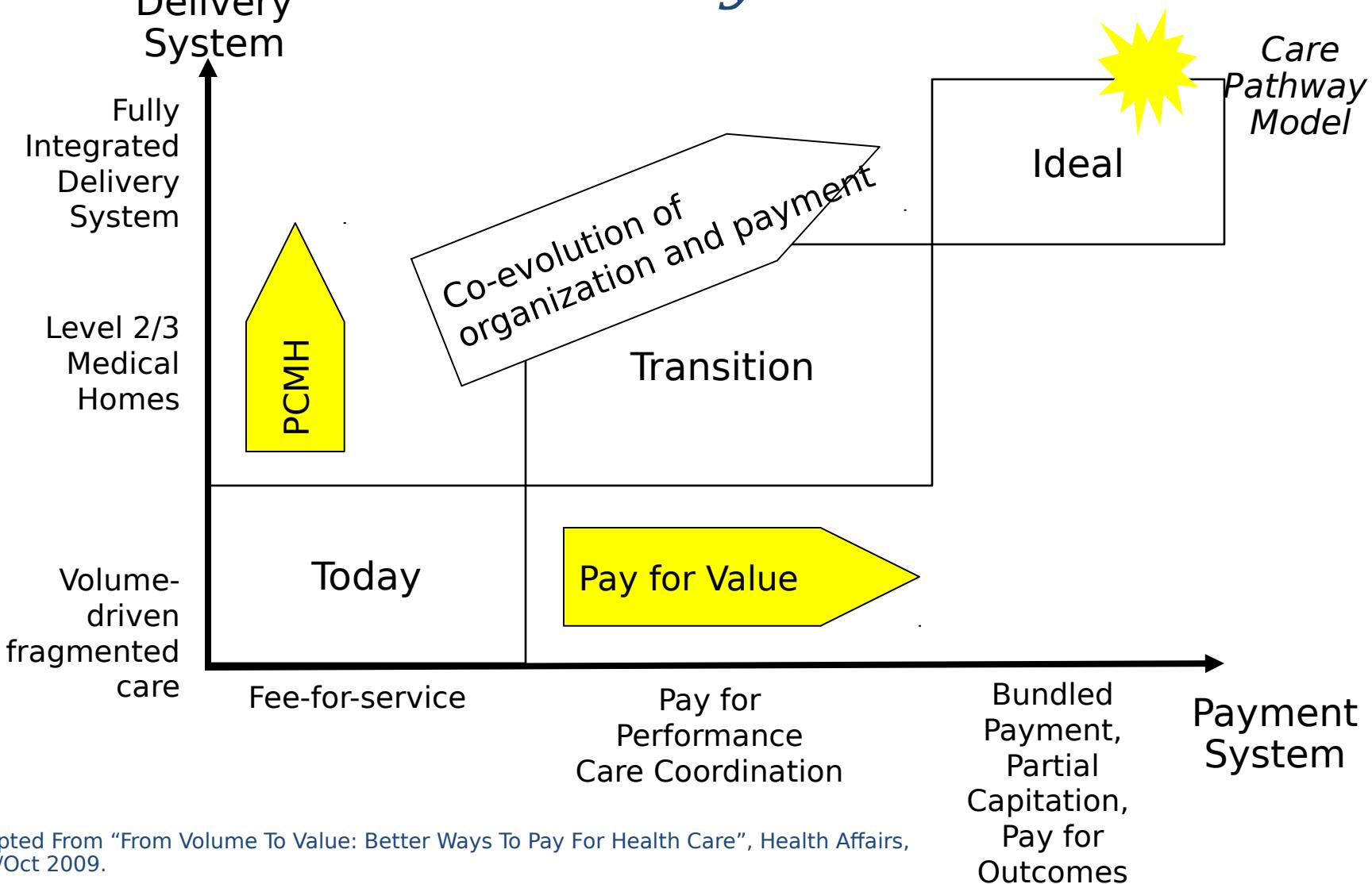
MHS Patient Centered Medical Home: Why a 4th Level MEPRS Code for Each Team is Worth the Effort



Revenue Cycle Conference

16 March 2011

The Essence of True Health Care Reform: Transitions in both Payment and Delivery



Adapted From "From Volume To Value: Better Ways To Pay For Health Care", Health Affairs, Sep/Oct 2009.

Overview

- Patient-Centered Medical Home (PCMH) is the strategic initiative expected to have the greatest impact on the Quadruple Aim
- Over the next few years, MHS plans to implement PCMH across the system

Projected Enrollees in Level 2/3 PCMH			
Service	FY10	FY11	FY12
Army	47,856 (3.4%)	281,506 (20%)	633,389 (45%)
Navy	132,683 (17%)	390,243 (50%)	597,361 (75%)
Air Force	304,723 (25%)	731,335 (60%)	1,103,864 (88%)

- MHS plans to invest >\$250M in PCMH over the FY12-16 POM
- What is the return on that investment

Correlating Growth in PCMH Enrollment to Quadruple Aim Performance

Expected Performance from PCMH

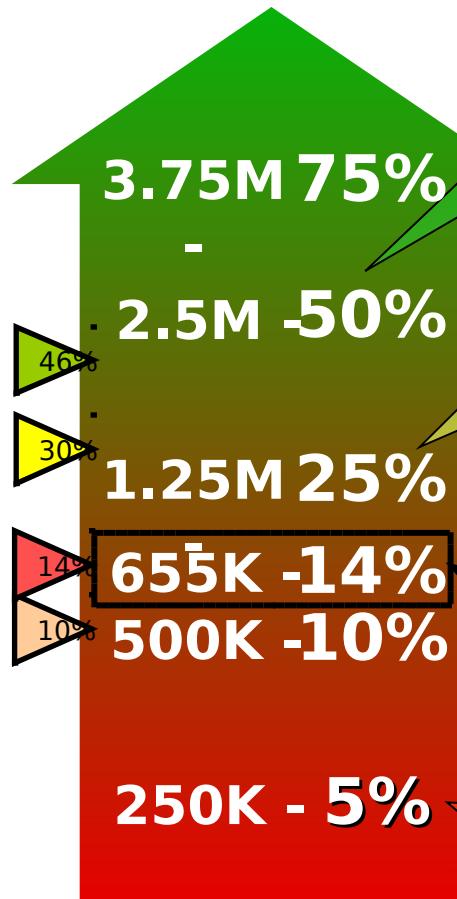
% of Enrollees Getting Care from PCMH

Overall Impact on Quadruple Aim

X

=

Current Perf	Measure	Expected Improvement
R	IMR	↑ TBD
G	HEDIS - Preventive	↑ 7%
G	HEDIS - Evidence Based Guidelines	↑ 4%
Y	Beneficiary Satisfaction	↑ 10%
Y	Time to Next Available Appt	↑ 15%
R	Getting Timely Care	↑ 14%
Y	PCM Continuity	↑ 16%
R	PMPM	↓ TBD
R	ER Utilization	↓ 15



Beneficiary Satisfaction: 59% → 64% (62%)

Getting Timely Care: 74% → 81% (78%)

PCM Continuity: 45% → 53% (60%)

ER Utilization: 45/100 → 37/100 (30)

Beneficiary Satisfaction: 59% → 62% (62%)

Getting Timely Care: 74% → 78% (78%)

PCM Continuity: 45% → 49% (60%)

ER Utilization: 45/100 → 41/100 (30)

Beneficiary Satisfaction: 59% → 60% (60%)

Getting Timely Care: 74% → 76% (77%)

PCM Continuity: 45% → 47% (60%)

ER Utilization: 45/100 → 43/100 (30)

Beneficiary Satisfaction: 59% → 59% (62%)

Getting Timely Care: 74% → 75% (78%)

PCM Continuity: 45% → 46% (60%)

Current Performance with 14% Enrolled in PCMH

60% ↑ 7%

42% ↑ 5%

45% ↑ 5%

60% ↑ 7%

42% ↑ 5%

60% ↑ 7%

42% ↑ 5%

60% ↑ 7%

42% ↑ 5%

ER Utilization: 45/100 → 44/100 (30)

(XX) Denotes FY12 target

Structural Elements of the PCMH

PCMH 1 - Access and Continuity

- A. Access During Office Hours
- B. Access After Hours
- C. Electronic Access
- D. Continuity
- E. Patient/Family Partnership
- F. Culturally and Linguistically Appropriate Practice
- G. Practice Organization

PCMH 2 - Identify and Manage Patient Populations

- A. Basic Data
- B. Searchable Clinical Data
- C. Comprehensive Health Assessment
- D. Using Data for Population Health Management

PCMH 3 - Plan and Manage Care

- A. Guidelines for Important Conditions
- B. Care Management
- C. Medication Management
- D. Electronic Prescribing

PCMH 4 - Self- Management Support

- A. Self-Care Process

PCMH 5 - Track and Coordinate Care

- A. Test Tracking and Follow-up
- B. Referral Tracking and Follow-up
- C. Coordination with Facilities
- D. Referrals to Community

PCMH 6 - Performance Measurement and Quality Improvement

- A. Measures of Performance
- B. Patient/Family Feedback
- C. Quality Improvement
- D. Electronic Reporting Performance

Other Structural Elements

- A. Staffing ratios
- B. Physical space
- C. Financial incentives (e.g., bonuses)

Differentiating Importance of NCQA PCMH Elements

While we have adopted the NCQA PCMH standards, we do not know which elements impact performance.

Additionally, some of these elements are costly to implement and some are not.

A baseline assessment of all MHS primary care practices will enable us to understand the relationship between structural elements and outcomes.

What is really different in a true Patient Centered Medical Home

- Key to success is the relationship
 - Different notion of what the job is – proactive population management vs sick visits
 - Real team based care – health coaches are key
 - Able to engage beyond the visit
 - Different culture – just say yes, think creatively
- In order to do this right, you have to change everything – business model, people, culture, process, space design, IT systems, external interfaces
- Half the effort will not get you half of the results

How will PCMH affect costs?

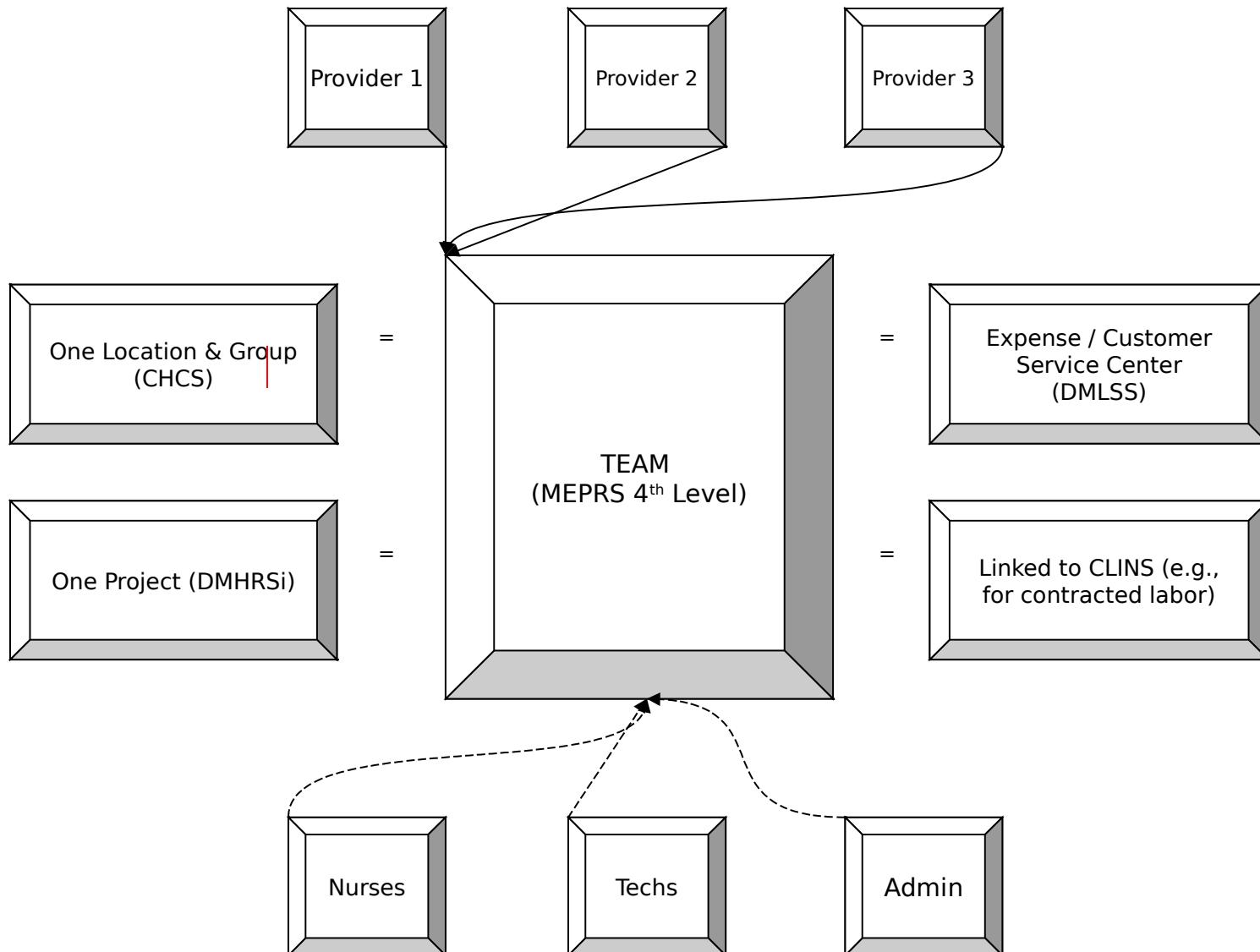
- One Example
 - Primary Care - Up by \$52 (down 4%)
 - Pharmacy - Up by \$73 (up 40%)
 - ER Visits - Down by \$29 (down 40%)
 - Hospitalizations - Down by \$351 (down 40%)
 - Net: Down \$255 (down 12%)
- But, we are different and we do not know if we can achieve the same level of savings.

How will we prove our case?

- Establish a baseline
- Implement the PCMH
- Study results.
- But, what level of granularity do we need for the analysis?

Our Assertion: Every patient centered medical home team is a work center and a cost center so each team should have its own 4th level MEPRS code

Connecting the Dots



Why the Need for 4th Level MEPRS?

- Affords the MHS the opportunity to centrally extract data to analyze PCMH team Quadruple Aim performance across the enterprise with regard to:
 - 1. Readiness
 - 2. Patient Experience
 - 3. Population Health
 - 4. Per Capita Costs
- Using place of care in CHCS could obtain data for numbers 1-3; but would not be able to obtain the financials stepped down at the team level
 - Ability to report to stakeholders the value of the PCMH key and having the financial is necessary so we can evaluate all components
 - Needed to implement sub-capitation and care management fee for performance planning pilots

Task at Hand



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

1200 DEFENSE PENTAGON
WASHINGTON, DC 20301-1200

FEB 11 2011

MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Memorandum Directing the Use of a Unique Fourth-Level Medical Expense
and Performance Reporting Code for Each Patient Centered Medical Home Team

A unique fourth-level Medical Expense and Performance Reporting System (MEPRS) code will be created and used to identify each individual patient centered medical home (PCMH) team within a Military Treatment Facility (MTF). This will enable the Military Health System to measure all aspects of the PCMH team in a consistent manner and allow for studying variation within each MTF, as well as across our system as a whole.

The MEPRS for Fixed Military Medical and Dental Treatment Facilities Manual (6010.13) delineates the criteria for establishing MEPRS codes. Services are to adhere to the guidance set forth in this document. The most current version of 6010.13 is available online at <http://www.mepsr.info>. Although 6010.13 states that the Services will determine if a specific work center is needed, each PCMH team should now be treated as a work center. The importance of monitoring success of the PCMH initiative requires such treatment.

This guidance will go into effect by March 1, 2011, and applies to all MTFs that have PCMHs. Questions concerning this policy should be directed to Ms. Paula Evans at (703) 681-1713, or Paula.Evans@tma.osd.mil.

JONATHAN WOODSON, M.D.

- Signed policy
- Goal today is to implement
 - Identify common processes, differences and obstacles
 - Ensure that TMA/HA assists in overcoming “system” obstacles?

“If there is no struggle, there is no progress” Fredrick Douglass